

# **Beginning Billing Workshop Hospice**

Colorado Medicaid  
2014





Centers for  
Medicare &  
Medicaid  
Services

Department of  
Health Care Policy  
and Financing



**Medicaid**

Medicaid/CHP+  
Medical Providers



Xerox State  
Healthcare

# Training Objectives

- Billing Pre-Requisites

- National Provider Identifier (NPI)

- What it is and how to obtain one

- Eligibility

- How to verify
    - Know the different types

- Billing Basics

- How to ensure your claims are timely

- When to use the UB-04 paper claim form

- How to bill when other payers are involved



# What is an NPI?

- National Provider Identifier
- Unique 10-digit identification number issued to U.S. health care providers by CMS
- All HIPAA covered health care providers/organizations must use NPI in all billing transactions
- Are permanent once assigned
  - Regardless of job/location changes



# What is an NPI?

- How to Obtain & Learn Additional Information:
  - CMS web page (paper copy)-
    - [www.dms.hhs.gov/nationalproidentstand/](http://www.dms.hhs.gov/nationalproidentstand/)
  - National Plan and Provider Enumeration System (NPPES)-
    - [www.nppes.cms.hhs.gov](http://www.nppes.cms.hhs.gov)
  - Enumerator-
    - 1-800-456-3203
    - 1-800-692-2326 TTY



# NEW! Department Website

1.

<https://www.colorado.gov/hcpf>

[www.colorado.gov/hcpf](https://www.colorado.gov/hcpf)

**COLORADO**

Department of Health Care  
Policy & Financing

Home

For Our Members

**For Our Providers**

For Our Stakeholders

Bo

2.

For Our Providers

We administer Medicaid, Child Health Plan *Plus*, and other health care programs for Coloradans who qualify.

Explore  
Benefits



Apply  
Now



Find  
Doctors



Get  
Help



**Feeling Sick?**

For medical advice, call the Nurse Line:

**800-283-3221**



**Get Covered.  
Stay Healthy.**

[colorado.gov/health](https://colorado.gov/health)

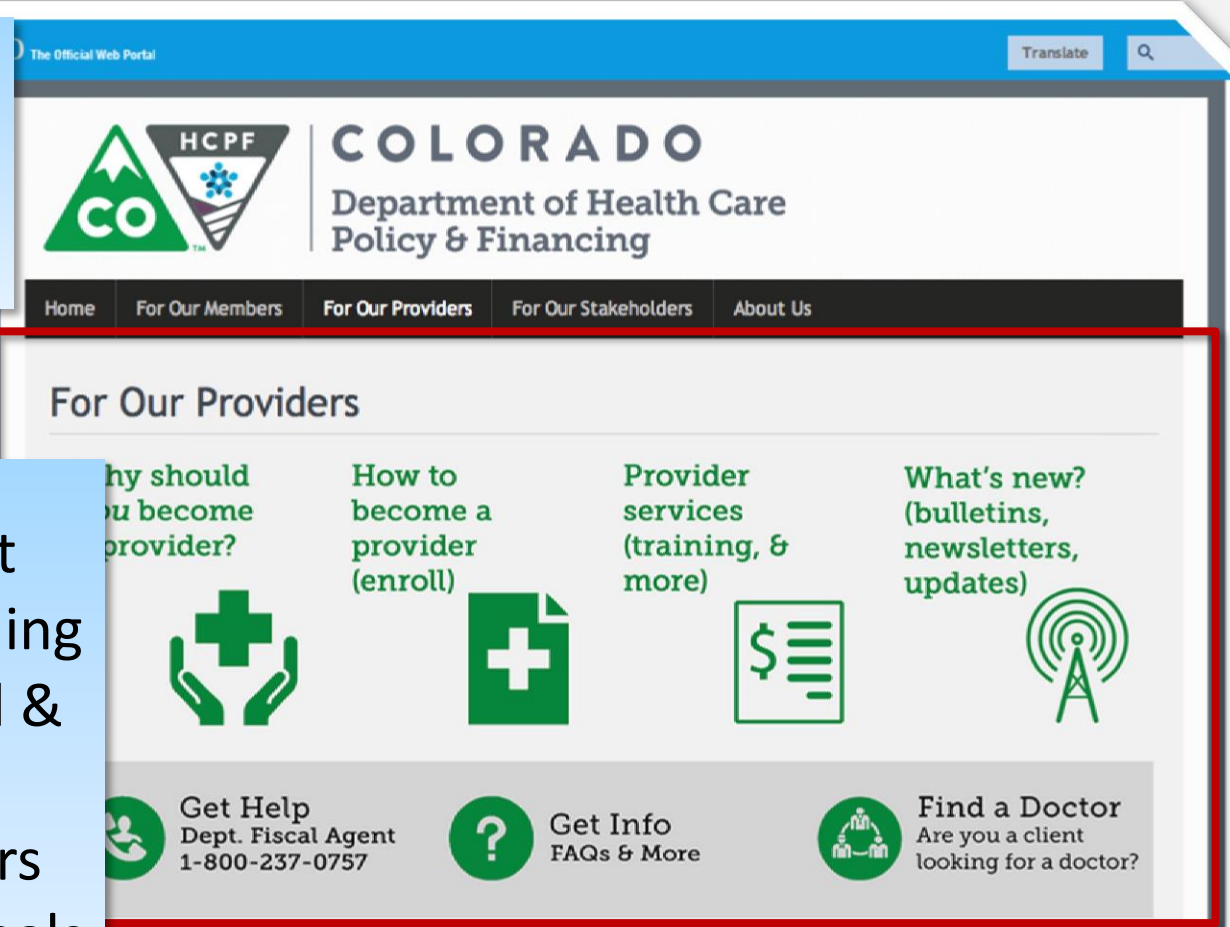


# NEW! Provider Home Page

Find what  
you need  
here



Contains important  
information regarding  
Colorado Medicaid &  
other topics of  
interest to providers  
& billing professionals



# Provider Enrollment

## Question:

What does Provider Enrollment do?



## Answer:

Enrolls providers into the Colorado Medical Assistance Program, not members

## Question:

Who needs to enroll?



## Answer:

Everyone who provides services for Medical Assistance Program members



# Attending Versus Billing

## Attending Provider

- Individual that provides services to a Medicaid member



## Billing Provider

- Entity being reimbursed for service



# Verifying Eligibility

- Always print & save copy of eligibility verifications
- Keep eligibility information in member's file for auditing purposes
- Ways to verify eligibility:



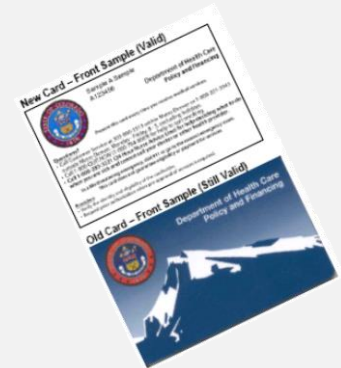
Web Portal



Fax Back  
1-800-493-0920



CMERS/AVRS  
1-800-237-0757



Medicaid ID Card  
with Switch  
Vendor

# Eligibility Response Information

- Eligibility Dates
- Co-Pay Information
- Third Party Liability (TPL)
- Prepaid Health Plan
- Medicare
- Special Eligibility
- BHO
- Guarantee Number



# Eligibility Request Response (271)

[Print](#)[Return To Eligibility Inquiry](#)

**Eligibility Request**

Provider ID:      National:

From DOS:      Through:

**Client Detail**

State ID:      DOB:

Last Name:      First:

CO MEDICAL ASSISTANT

Response Creation Date & Time: 05/06/2011 10:00:00 AM

[Contact Information for Questions or Comments](#)

Provider Relations Number: 800-237-2262

[Requesting Provider](#)

Provider ID:      Name:

[Client Details](#)

Name:      State ID:

[Client Eligibility Details](#)

Eligibility Status: **Eligible**

Eligibility Benefit Date: 04/06/2011 - 04/06/2011

Guarantee Number: **111400000000**

Coverage Name: Medicaid

**PREPAID HEALTH PLAN OR ACCOUNTABLE CARE COLLABORATIVE**

Eligibility Benefit Date: 04/06/2011 - 04/06/2011

Messages:

**MHPROV Services**

Provider Name: **COLORADO HEALTH PARTNERSHIPS LLC**

Provider Contact Phone Number: 800-804-5008

Information appears in sections (Requesting Provider, Member Details, Member Eligibility Details, etc.). Use the scroll bar to the right to view more details.

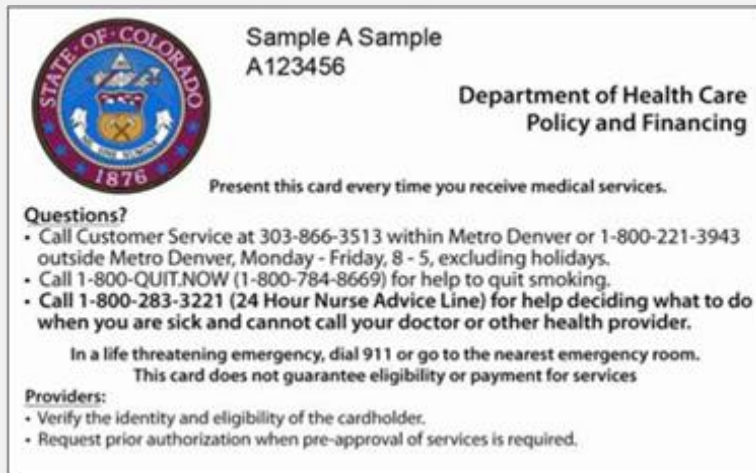
A successful inquiry notes a Guarantee Number. Print a copy of the response for the member's file when necessary.

As a reminder, information received is based on what is available through the Colorado Benefits Management System (CBMS). Updates may take up to 72 hours.



# Medicaid Identification Cards

- Both cards are valid
- Identification Card does not guarantee eligibility



# Eligibility Types

- Most members= Regular Colorado Medicaid benefits
- Some members= different eligibility type
  - Modified Medical Programs
  - Non-Citizens
  - Presumptive Eligibility
- Some members= additional benefits
  - Managed Care
  - Medicare
  - Third Party Insurance



# Eligibility Types

## Modified Medical Programs



- Members are not eligible for regular benefits due to income
- Some Colorado Medical Assistance Program payments are reduced
- Providers cannot bill the member for the amount not covered
- Maximum member co-pay for OAP-State is \$300
- Does not cover:
  - Long term care services
  - Home and Community Based Services (HCBS)
  - Inpatient, psych or nursing facility services



# Eligibility Types

## Non-Citizens



- Only covered for admit types:
  - Emergency = 1
  - Trauma = 5
- Emergency services (must be certified in writing by provider)
  - Member health in serious jeopardy
  - Seriously impaired bodily function
  - Labor / Delivery
- Member may not receive medical identification care before services are rendered
- Member must submit statement to county case worker
- County enrolls member for the time of the emergency service only

# What Defines an “Emergency”?

- **Sudden, urgent, usually unexpected** occurrence or occasion requiring immediate action such that of:
  - Active labor & delivery
  - Acute symptoms of sufficient severity & severe pain-
    - Severe pain in which, the absence of immediate medical attention might result in:
      - Placing health in serious jeopardy
      - Serious impairment to bodily functions
      - Dysfunction of any bodily organ or part



# Eligibility Types

## Presumptive Eligibility



- Temporary coverage of Colorado Medicaid or CHP+ services until eligibility is determined
  - Member eligibility may take up to 72 hours before available
- Medicaid Presumptive Eligibility is only available to:
  - Pregnant women
    - Covers DME and other outpatient services
  - Children ages 18 and under
    - Covers all Medicaid covered services
  - Labor / Delivery
- CHP+ Presumptive Eligibility
  - Covers all CHP+ covered services, except dental



# Presumptive Eligibility

## Presumptive Eligibility



- Verify Medicaid Presumptive Eligibility through:
  - Web Portal
  - Faxback
  - CMERS
    - May take up to 72 hours before available
- Medicaid Presumptive Eligibility claims
  - Submit to the Fiscal Agent
    - Xerox Provider Services- 1-800-237-0757
- CHP+ Presumptive Eligibility and claims
  - Colorado Access- 1-888-214-1101



# Managed Care Options

- Types of Managed Care options:
  - Managed Care Organizations (MCOs)
  - Behavioral Health Organization (BHO)
  - Program of All-Inclusive Care for the Elderly (PACE)
  - Accountable Care Collaborative (ACC)



# Managed Care Options

## Managed Care Organization (MCO)



- Eligible for Fee-for-Service if:
  - MCO benefits exhausted
    - Bill on paper with copy of MCO denial
  - Service is not a benefit of the MCO
    - Bill directly to the fiscal agent
  - MCO not displayed on the eligibility verification
    - Bill on paper with copy of the eligibility print-out



# Managed Care Options

Behavioral Health  
Organization (BHO)



- Community Mental Health Services Program
  - State divided into 5 service areas
    - Each area managed by a specific BHO
  - Colorado Medical Assistance Program Providers
    - Contact BHO in your area to become a Mental Health Program Provider



# Managed Care Options

## Accountable Care Collaborative (ACC)



- Connects Medicaid members to:
  - Regional Care Collaborative Organization (RCCO)
  - Medicaid Providers
- Helps coordinate Member care
  - Helps with care transitions

# Medicare

## Medicare



- Medicare members may have:
  - Part A only- covers Institutional Services
    - Hospital Insurance
  - Part B only- covers Professional Services
    - Medical Insurance
  - Part A and B- covers both services
  - Part D- covers Prescription Drugs

# Medicare

## Qualified Medicare Beneficiary (QMB)



- Bill like any other TPL
- Members only pay Medicaid co-pay
- Covers any service covered by Medicare
  - QMB Medicaid- members also receive Medicaid benefits
  - QMB Only- members do not receive Medicaid benefits
    - Pays only coinsurance and deductibles of a Medicare paid claim



# Medicare-Medicaid Enrollees

- Eligible for both Medicare & Medicaid
- Formerly known as “Dual Eligible”
- Medicaid is always **payer of last resort**
  - Bill Medicare first for Medicare-Medicaid Enrollee members
- Retain proof of:
  - **Submission to Medicare prior to** Colorado Medical Assistance Program
  - Medicare denials(s) for **six years**



# Third Party Liability

## Third Party Liability



- Colorado Medicaid pays Lower of Pricing (LOP)

- Example:

- Charge = \$500
- Program allowable = \$400
- TPL payment = \$300
- Program allowable – TPL payment = LOP

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**\$400.00**

- \$300.00

---

= \$100.00

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# Commercial Insurance

## Commercial Insurance



- Colorado Medicaid always payor of last resort
- Indicate insurance on claim
- Provider cannot:
  - Bill member difference or commercial co-payments
  - Place lien against members right to recover
  - Bill at-fault party's insurance

# Billing Overview

- Record Retention
- Claim submission
- Prior Authorization Requests (PARs)
- Timely filing
- Extensions for timely filing



# Record Retention

- Providers must:
  - Maintain records for at least 6 years
  - Longer if required by:
    - Regulation
    - Specific contract between provider & Colorado Medical Assistance Program
  - Furnish information upon request about payments claimed for Colorado Medical Assistance Program services



# Record Retention

- Medical records must:
  - Substantiate submitted claim information
  - Be signed & dated by person ordering & providing the service
    - Computerized signatures & dates may be used if electronic record keeping system meets Colorado Medical Assistance Program security requirements



# Submitting Claims

- Methods to submit:
  - Electronically through **Web Portal**
  - Electronically using **Batch Vendor, Clearinghouse, or Billing Agent**
  - Paper **only when**
    - Pre-approved (consistently submits less than 5 per month)
    - Claims require attachments



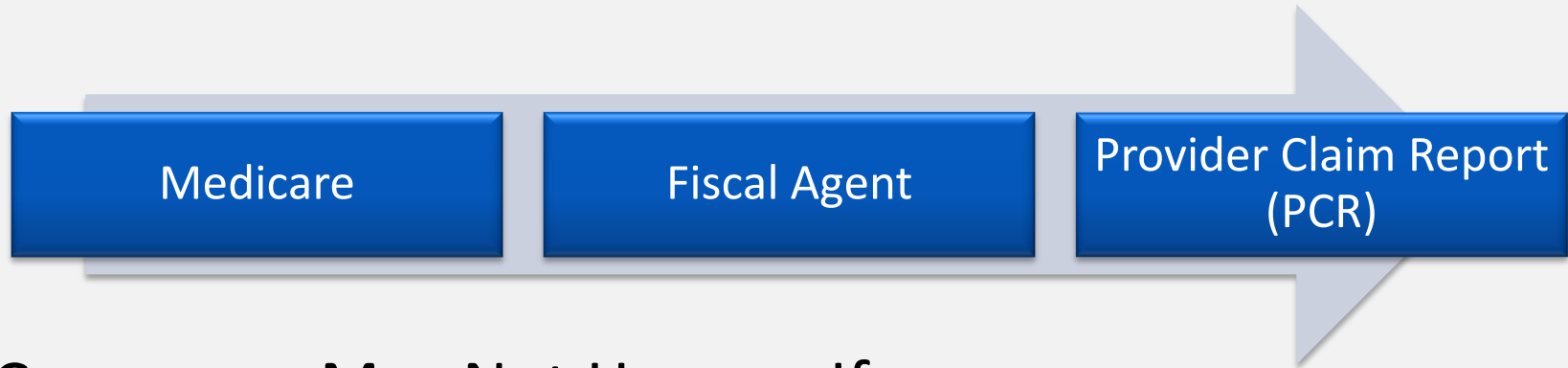
# ICD-10 Implementation Delay

- ICD-10 Implementation delayed until 10/1/2015
  - ICD-9 codes: Claims with Dates of Service (DOS) on or before 9/30/15
  - ICD-10 codes: Claims with DOS 10/1/2015 or after
  - Claims submitted with both ICD-9 and ICD-10 codes will be rejected



# Crossover Claims

- Automatic Medicare Crossover Process:

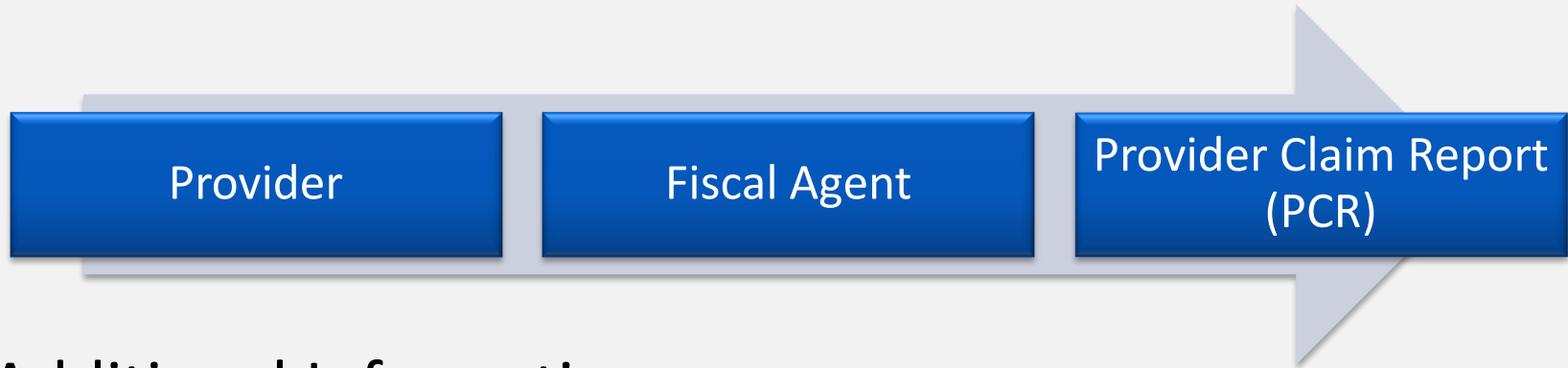


- Crossovers May Not Happen If:

- NPI not linked
- Member is a retired railroad employee
- Member has incorrect Medicare number on file

# Crossover Claims

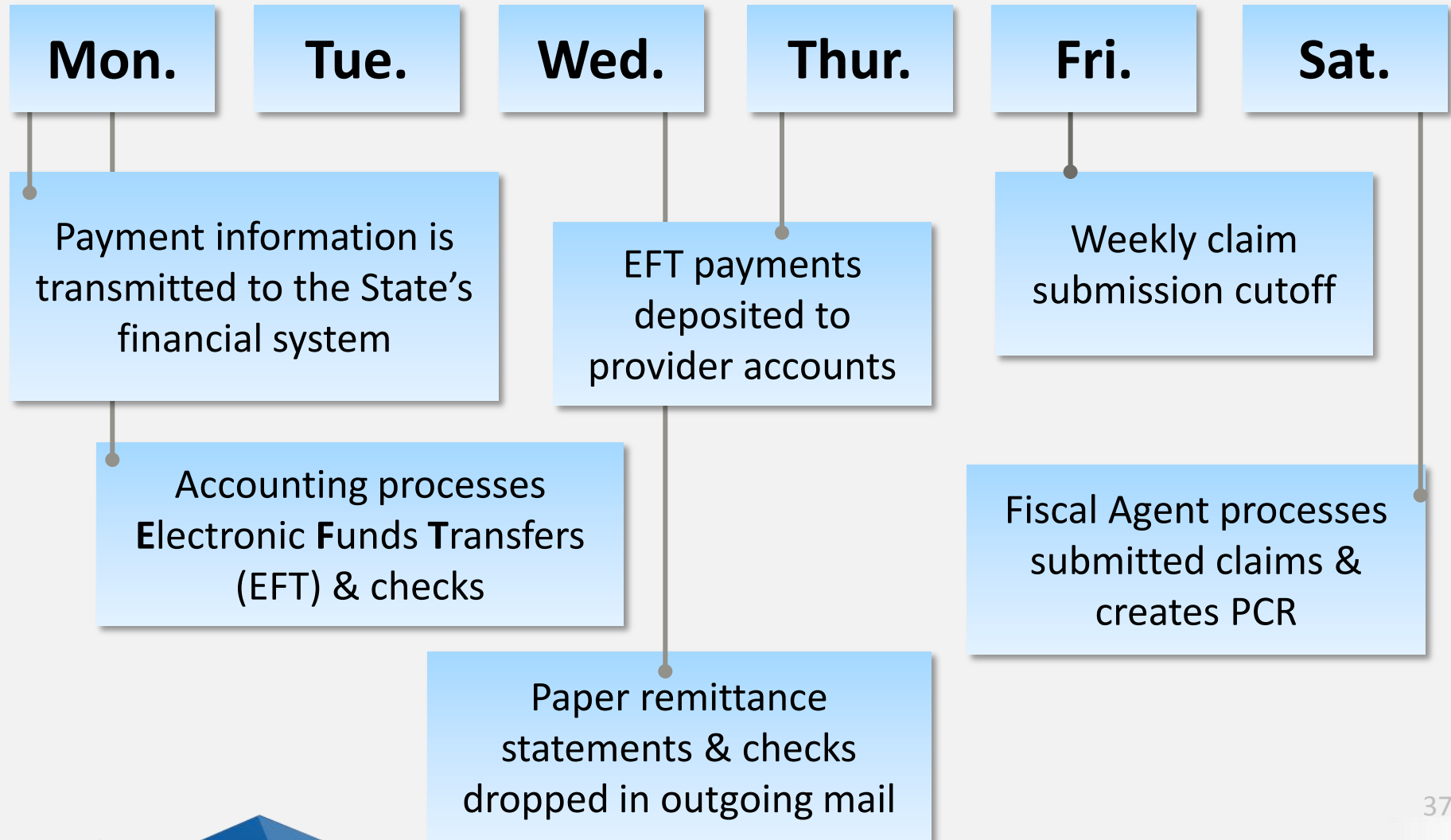
- Provider Submitted Crossover Process:



- Additional Information:

- Submit claim yourself if Medicare crossover claim not on PCR within 30 days
- Crossovers may be submitted on paper or electronically
- Providers must submit copy of SPR with paper claims
- Provider must retain SPR for audit purposes

# Payment Processing Schedule



# Electronic Funds Transfer (EFT)

- Several Advantages:

- Free!
- No postal service delays
- Automatic deposits every Friday
- Safest, fastest & easiest way to receive payments
- Located in Provider Services Forms section on Department website



# Transaction Control Number

## Receipt Method

0 = Paper  
2 = Medicare Crossover  
3 = Electronic  
4 = System Generated

## Batch Number

## Document Number

0 14 129 00 150 0 00037

## Year of Receipt

## Julian Date of Receipt

## Adjustment Indicator

1 = Recovery  
2 = Repayment

# Timely Filing

- 120 days from Date of Service (DOS)
  - Determined by date of receipt, not postmark
  - PARs are not proof of timely filing
  - Certified mail is not proof of timely filing
  - Example – DOS January 1, 20XX:
    - Julian Date: 1
    - Add: 120
    - Julian Date = 121
    - Timely Filing = Day 121 (May 1st)



# Timely Filing

## From “through” DOS

- Nursing Facility
- Home Health
- Waiver
- In- & Outpatient
- UB-04 Services

## From DOS

- FQHC Separately Billed and additional Services

## From delivery date

- Obstetrical Services
- Professional Fees
- Global Procedure Codes:
  - Service Date = Delivery Date

# Documentation for Timely Filing

- 60 days from date on:
  - Provider Claim Report (PCR) Denial
  - Rejected or Returned Claim
  - Use delay reason codes on 837I transaction
  - Keep supporting documentation
- Paper Claims
  - UB-04- Enter Occurrence Code 53 and the date of the last adverse action



# Timely Filing – Medicare/Medicaid Enrollees

Medicare pays claim



- 120 days from Medicare payment date

Medicare denies claim



- 60 days from Medicare denial date



# Timely Filing Extensions

- Extensions may be allowed when:
  - Commercial insurance has yet to pay/deny
  - Delayed member eligibility notification
    - Delayed Eligibility Notification Form
  - Backdated eligibility
    - Load letter from county



# Extensions – Commercial Insurance

- 365 days from DOS
- 60 days from payment/denial date
- When nearing the 365 day cut-off:
  - File claim with Colorado Medicaid
    - Receive denial or rejection
  - Continue re-filing every 60 days until insurance information is available



# Extensions – Delayed Notification

- 60 days from eligibility notification date
  - Certification & Request for Timely Filing Extension – Delayed Eligibility Notification Form
    - Located in Forms section
    - Complete & retain for record of LBOD
- Bill electronically
  - If paper claim required, submit with copy of Delayed Eligibility Notification Form
- Steps you can take:
  - Review past records
  - Request billing information from member



# Extensions – Backdated Eligibility

- 120 days from date county enters eligibility into system
- Report by obtaining State-authorized letter identifying:
  - County technician
  - Member name
  - Delayed or backdated
  - Date eligibility was updated



# Hospice

- Hospice services are available to Medical Assistance Program members with a terminal illness
  - Life expectancy of 9 months or less
  - Palliative treatments include:
    - hospice services & interventions that are not curative
    - but provide the greatest degree of relief & comfort for symptoms of terminal illness



# Hospice Members in a Nursing Facility

- ULTC 100.2

- Not required if member has already been determined eligible for Medicaid when hospice member enters a nursing facility (NF)
- Required if Medicaid eligibility for hospice member is pending
- Required if member does not have an active ULTC 100.2 & leaves hospice status and remains in NF



# Nursing Facility Patient Pay

- If member expires during the month
  - Patient pay goes to NF if patient pay is equal to or less than NF charge
  - Amount is pro-rated if patient pay is greater than NF charge
- Nursing Facility is responsible for collecting the patient payment & Hospice rate and to report it on the claim
- Obtain patient pay amount from NF & always include amount on claim



# Post Eligibility Treatment of Income (PETI)

If a member does not make a patient payment -  
there is No PETI!!



# Post Eligibility Treatment of Income (PETI)

- Reduction of resident payment to an NF for costs of care provided to the resident for services that are:
  - Medically necessary
  - Not covered by Medicaid
- Reduced by amount that remains after certain County-approved deduction are applied, as reflected on the 5615
  - Reimbursement by Medicaid is subject to reasonable limits set by the Department



# To Access PETI

- **All** other payer sources must have been **exhausted**
- **Cannot** be a covered Medicaid service

**OR**

- Must have Medicaid denial
  - You must first submit a claim to the Colorado Medical Assistance program

# PETI Process Overview



- NF or family pays provider
  - Usually done once PETI approval received

- NF reports PETI on:
  - 837I
  - UB 04

# To Submit PETI Request

- All NF PETI requests must include the following two forms
  - Nursing Facility Post Eligibility Treatment of Income Request (NF PETI) Program form
  - NF PETI Medical Necessity Certification form
- All required signatures
- All supporting documents
- Provider statement
- Provider's invoice
- Medicaid Program denial PCR (if applicable)



# PETI – Submit to Fiscal Agent

- May submit NF PETI directly to the Department's fiscal agent, without first submitting to the Department if:
  - All combined request(s) per calendar year are under \$400
  - Requested service is not an adult benefit of Medicaid per PETI fee schedule



# PETI – Submit to Department

- Submit to the Department first if:
  - Charges exceeding \$400 per year and all health insurance charges must be prior authorized by Department
  - If the fee schedule notes an MP (Manually Priced) then submit to the department



# PETI Billing

- Provider is not required to be enrolled in Medicaid in order to provide services to PETI-eligible residents
- Submit claims for approved NF PETI amounts on claim with:
  - member's room and board amount
  - patient liability amount
- Claims processing system automatically completes the calculations
- PETI documentation shall be retained by NF for 6 years for audit purposes



# PETI – If...Then

**If:** provider is requesting more than what is allowed on PETI fee schedule



**Then:** this amount must be amended to what is allowable on the PETI fee schedule

**If:** member has medical trust



**Then:** PETI charges must be paid from medical trust



# PETI Revenue Codes

- 999 – Health Insurance Premiums & Other Services
  - All premiums must first be approved by State
- 962 – Vision & Eye Care
- 479 – Hearing & Ear Services
- Claims must have Accommodation Revenue Code:
  - 119 Private
    - Must be approved by Colorado Medicaid
  - 129 Semi-Private
- Claims must have a patient liability



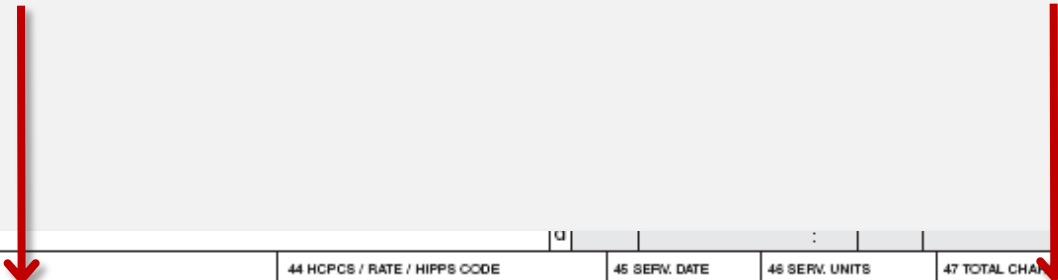
# PETI Occurrence Span Dates

- Date(s) services rendered or insurance payments made
  - May be single dates
  - No future dates
- Span dates do not have to fall within Statement Covers Period

36	OCCURRENCE SPAN	
CODE	FROM	THROUGH
76	03/06/2014	03/06/2014

# PETI Services

- Enter approved amount paid to service providers



42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 129	Semi-Private	90.05		30	2701.50		1
2 479	Hearing and Ear Care			1	35.00		2
3 962	Vision Care			1	30.00		3

# PETI Services

- Charges must be less than or equal to patient payment entered for Value Code 31 (Patient Liability Amount)

39			39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	80	30:00						
b	31	103:00						
c								
d								

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
129	Semi-Private	90.05		30	2701.50		
479	Hearing and Ear Care			1	35.00		
962	Vision Care			1	30.00		

# Nursing Facility Contacts

To send NF PETI requests to the Department

Nursing Facility PETI Program  
Department of Health Care Policy & Financing  
1570 Grant Street  
Denver, CO 80203  
Fax: 303.866.3991

For NF PETI related questions  
not directly related to billing  
please contact Susan Love at 303-866-4158



# Colorado 1500

**What services are billed on the Colorado 1500?**

Medical Director

Interventions



# UB-04

## What services are billed on the UB-04?

Hospice Routine  
Home Care

Hospice Inpatient  
Respite

Continuous Home  
Care

Hospice Physician  
Service (Visit)

# UB-04


The image shows a sample UB-04 institutional claim form. A large, diagonal 'Sample' watermark is overlaid across the center of the form. The form is divided into several sections with numbered fields. Key sections include:
 

- Header Section:** Fields for patient name, address, birth date, sex, admission date, and statement covered period.
- Occurrence Section:** Multiple rows for recording procedure codes, dates, and amounts.
- Charges Section:** Fields for total charges, non-covered charges, and other financial details.
- Insurance Information Section:** Fields for insurer name, insured's unique ID, and group name.
- Remarks Section:** A large area at the bottom for additional notes and remarks.

 The form is labeled 'UB-04 CMS-1450' at the bottom left and includes a note about the reverse side: 'THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.'

- UB-04 is the standard institutional claim form used by Medicare and Medicaid Assistance Programs
- Where can a Colorado Medical Assistance provider get the UB-04?
  - Available through most office supply stores
  - Sometimes provided by payers

# UB-04 Certification



**Colorado Medical Assistance Program**

**Institutional Provider Certification**

This is to certify that the foregoing information is true, accurate and complete.

This is to certify that I understand that payment of this claim will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State Laws.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This document is an addendum to the UB-04 claim form and is required per 42 C.F.R. 445.18 (a)(1-2) to be attached to paper claims submitted on the UB-04.

UB-04 certification must be completed and attached to all claims submitted on the paper UB-04

Print a copy of the certification at:  
[colorado.gov/hcpf/provider-forms](http://colorado.gov/hcpf/provider-forms)

# UB-04 Tips

Do

- Submit multiple-page claims electronically

Do not

- Submit “continuous” claims
- Add more lines on the form
  - Each claim form has set number of available billing lines
  - Billing lines in excess of designated number are **not processed or acknowledged**

# UB-04 Claims Submission

1 Hospice Agency 100 Saginaw Street Anytown, CO 80201 303-333-3333										2										3a PAT. CNTL # SM000123										4 TYPE OF BILL 812																																																																																																																																	
8 PATIENT NAME a Client, Ima D.										9 PATIENT ADDRESS a 123 Main Street										5 FED. TAX NO.										6 STATEMENT COVERS PERIOD FROM 01/06/08 THROUGH 01/31/08										7																																																																																																																							
b Anytown										c CO										d 88888										e																																																																																																																																	
10 BIRTHDATE 02/13/1980										11 SEX F										12 DATE 12/06/03										13 ADMISSION 13 HR 14 TYPE 15 SRC 16 DHR 17 STAT 1										18										19										20										21										22										23										24										25										26										27										28										29 ACCT STATE 30									
31 OCCURRENCE CODE 27										32 OCCURRENCE DATE 01/01/08										33										34										35										36										37										38										39										40										41										42																																																	

Occurrence Code 27  
Hospice plan established

30 – Still patient  
40 – Expired at home  
41 – Expired - SNF/other facility  
42 – Expired – Place unknown



# UB-04 Claims Submission

Rev Codes  
calculated in  
**days** -

- 651
- 655
- 656
- 659

Rev Codes  
calculated in  
**hours** -

- 652

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
651	Hospice Routine Home Care		01/06/08	8	624:00		1
652	Hospice Continuous Home Care		01/18/08	24	480:00		2
652	Hospice Continuous Home Care		01/19/08	16	320:00		3
652	Hospice Continuous Home Care		01/20/08	8	160:00		4
655	Hospice Inpatient Respite		01/21/08	3	249:00		5
656	Hospice General Inpatient Care		01/24/08	1	350:00		6
651	Hospice Routine Home Care		01/25/08	9	702:00		7
659	Nursing Facility R & B Per Diem		01/06/08	20	1100:00		8

- MMIS makes all claim calculations
  - Bill full \$100.00
  - (per diem rate) amount
  - Reimbursement for rev code 659 is calculated (systematically) at 95% of NF per diem, minus patient payment

72

# UB-04 Claims Submission

- Common Billing Issues

- Hospice units of service are invalid if
  - More than 5 days of respite care (655) is billed
  - Less than 8 or more than 24 hours of continuous home care (652) are billed on single date
- Units greater than total days
  - Units of service total more than statement covered days
- Payment is made for date of death and day of discharge for all rev codes, excluding 659
- Payment for rev code 659 includes day of death, but not day of discharge



# Date of Death

- Payment is made for date of death and day of discharge (DOD) for all rev codes except for 659
  - Rev code 659 only includes:
    - the date of death
    - not the day of discharge
  - Home care rate applies if discharge is from general or respite inpatient care
    - unless member dies at an inpatient level of care
    - Inpatient level of care – the applicable general or respite rate is paid for discharge rate



# Date of Death

- Payment for NF residents is made for services delivered up to date of discharge (alive or deceased)
  - Includes applicable per diem payment for DOD
- For the month of the member's death, the following are allowable
  - Durable medical rental equipment
  - Oxygen

# Common Denial Reasons

## Timely Filing



Claim was submitted more than 120 days without a LBOD

## Duplicate Claim



A subsequent claim was submitted after a claim for the same service has already been paid.

## Bill Medicare or Other Insurance



Medicaid is always the “Payor of Last Resort”. Provider should bill all other appropriate carriers first



# Common Denial Reasons

**PAR not on file**



No approved authorization on file for services that are being submitted

**Total Charges  
invalid**



Line item charges do not match the claim total

**Type of Bill**



Claim was submitted with an incorrect or invalid type of bill



# Claims Process - Common Terms



**Reject**

Claim has primary data edits – **not** accepted by claims processing system



**Denied**

Claim processed & denied by claims processing system



**Accept**

Claim accepted by claims processing system



**Paid**

Claim processed & paid by claims processing system

# Claims Process - Common Terms



Correcting  
under/overpayments,  
claims paid at zero &  
claims history info

**Adjustment**



Re-bill previously  
denied claim

**Rebill**



Claim must be  
manually reviewed  
before adjudication

**Suspend**



“Cancelling” a  
“paid” claim  
(wait 48 hours to  
rebill)

**Void**

# Adjusting Claims

- **What is an adjustment?**

- Adjustments create a replacement claim
- Two step process: Credit & Repayment

## Adjust a claim when:



- Provider billed incorrect services or charges
- Claim paid incorrectly

## Do not adjust when:



- Claim was denied
- Claim is in process
- Claim is suspended



# Adjustment Methods



## Web Portal

- Preferred method
- Easier to submit & track

Colorado Medical Assistance Program  
PO Box 90  
Denver, Colorado 80201-0090

**Adjustment Transmittal**

Complete a separate Adjustment Transmittal for each claim and include the following:  
1) Attach a copy of the replacement claim (when applicable - see directions)  
2) A copy of the Provider Claim Report (PCR) showing the most recent payment  
3) Medicare TPL - A copy of the Standard Paper Remittance (SPR) (when applicable)  
**Do not use to rebill denied claims.**

Provider Name	Claim Type:
Street Address (Address used to Return To Provider (RTP))	<input type="checkbox"/> Colorado 1500 <input type="checkbox"/> 837P
City, State, Zip Code	<input type="checkbox"/> Pharmacy <input type="checkbox"/> EPSDT
Telephone Number	<input type="checkbox"/> Dental <input type="checkbox"/> 837D
Billing Provider Medicaid ID Number	<input type="checkbox"/> UB-04 <input type="checkbox"/> 837I
Billing Provider National Provider Identifier (NPI)	

**ALL FIELDS BELOW MUST BE COMPLETED**

Client ID Number	Client Name
Date of Service	Provider Claim Report (PCR) Date

**Do not use the Adjustment Transmittal to rebill denied or already voided claims.**  
**Adjustment Transmittals are used to adjust paid claims only.**  
**Enter the Transaction Control Number (TCN) below (14 or 17 characters):**

Three-digit reason code indicating the reason for the Adjustment

☐ 406 claim replacement - Requires a replacement claim to include original claim data plus amended and/or additional services and charges (on the replacement claim, please highlight the amended information). For example, if you are adding a line to the claim, include the original claim information plus the additional line and charges associated. If the original claim had one line, the replacement claim should now show two lines.

☐ 412 claim credit (recovery) - Replacement claim not required. This will void the entire claim and produce a take back for the entire amount. Rebill when appropriate.

Date: \_\_\_\_\_ By (Provider Signature): \_\_\_\_\_

**FISCAL AGENT USE ONLY**

Reply (notes) and RTP reason code

Unarchive required ☐ Yes ☐ No

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## Paper

- Complete Adjustment Transmittal form
- Be concise & clear



# Provider Claim Reports (PCRs)

- Contains the following claims information:
  - Paid
  - Denied
  - Adjusted
  - Voided
  - In process
- Providers required to retrieve PCR through File & Report Service (FRS)
  - Via Web Portal



# Provider Claim Reports (PCRs)

- Available through FRS for 60 days
- Two options to obtain duplicate PCRs:
  - Fiscal agent will send encrypted email with copy of PCR attached
    - \$2.00/ page
  - Fiscal agent will mail copy of PCR via FedEx
    - Flat rate- \$2.61/ page for business address
    - \$2.86/ page for residential address
- Charge is assessed regardless of whether request made within 1 month of PCR issue date or not



# Provider Claim Reports (PCRs)

## Paid

\*\*\*\*\*  
\* CLAIMS PAID \*  
\*\*\*\*\*

INVOICE NUM	CLIENT NAME	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SVC FROM TO	TOTAL CHARGES	ALLOWED CHARGES	COPAY PAID	AMT OTH SOURCES	CLM PMT AMOUNT
7015	CLIENT, IMA	Z000000	040800000000000001	040508 040508	132.00	69.46	2.00	0.00	69.46
PROC CODE - MODIFIER 99214 -					040508 040508	132.00	69.46	2.00	
TOTALS - THIS PROVIDER / THIS CATEGORY OF SERVICE ....					TOTAL CLAIMS PAID	1	TOTAL PAYMENTS		69.46

## Denied

\*\*\*\*\*  
\* CLAIMS DENIED \*  
\*\*\*\*\*

INVOICE NUM	CLIENT NAME	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SERVICE FROM TO	TOTAL DENIED	DENIAL REASONS ERROR CODES
STEDOTCCIOT	CLIENT, IMA	A000000	308000000000000003	03/05/08 03/06/08	245.04	1348
TOTAL CLAIMS DENIED - THIS PROVIDER / THIS CATEGORY OF SERVICE						1

THE FOLLOWING IS A DESCRIPTION OF THE DENIAL REASON (EXC) CODES THAT APPEAR ABOVE:

1348	The billing provider specified is not a fully active provider because they are enrolled in an active/non-billable status of '62', '63', '64', or '65' for the FDOS on the claim. These active/non-billable providers can't receive payment directly. The provider must be in a fully active enrollment status of '60' or '61'.	COUNT 0001
------	--	------------



# Provider Claim Reports (PCRs)

## Adjustments

## Recovery

***** * ADJUSTMENTS PAID * *****										
INVOICE --- CLIENT	-----	TRANSACTION	DATES OF SVC	ADJ	TOTAL	ALLOWED	COPAY	AMT OTH	CLM PMT	
NUM	NAME	STATE ID	CONTROL NUMBER	FROM	TO	RSN	CHARGES	CHARGES	PAID	SOURCES
Z71	CLIENT, IMA	A000000	40800000000100002	041008	041808	406	92.82-	92.82-	0.00	0.00
										92.82-
	PROC CODE - MOD	T1019 - U1		041008	091808		92.82-	92.82-		
Z71	CLIENT, IMA	A000000	40800000000200002	041008	041808	406	114.24	114.24	0.00	0.00
										114.24
	PROC CODE - MOD	T1019 - U1		041008	041808		114.24	114.24		
							NET IMPACT	21.42		

## Net Impact

## Repayment

## Voids

### \* ADJUSTMENTS PAID \*

***** * ADJUSTMENTS PAID * *****										
INVOICE - CLIENT	-----	TRANSACTION	DATES OF SVC	ADJ	TOTAL	ALLOWED	COPAY	AMT OTH	CLM PMT	
NUM	NAME	STATE ID	CONTROL NUMBER	FROM	TO	RSN	CHARGES	CHARGES	PAID	SOURCES
A83	CLIENT, IMA	Y000002	40800000000100009	040608	042008	212	642.60-	642.60-	0.00	0.00
										642.60-
	PROC CODE - MOD	T1019 - U1		040608	042008		642.60-	642.60-		
							NET IMPACT	642.60-		



# Provider Services

## **Xerox**

**1-800-237-0757**

Claims/Billing/ Payment

Forms/Website

EDI

Enrolling New Providers

Updating existing provider profile

## **CGI**

**1-888-538-4275**

Email [helpdesk.HCG.central.us@cgi.com](mailto:helpdesk.HCG.central.us@cgi.com)

CMAP Web Portal technical support

CMAP Web Portal Password resets

CMAP Web Portal End User training

# Thank You!

